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BEFORE THE
PHYSICIAN ASSISTANT BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **RICHARD HERNANDEZ REGALADO, P.A.** **3332 Columbia Ave.** **Merced, CA 95340** **Physician Assistant License No. PA 10871** Respondent.	Case No. 1E-2012-221415 **ACCUSATION**

Complainant alleges:

PARTIES

1. Glenn L. Mitchell, Jr. (Complainant) brings this Accusation solely in his official capacity as the Executive Officer of the Physician Assistant Board, Department of Consumer Affairs.

2. On or about March 18, 1981, the Physician Assistant Board of California (Board) issued Physician Assistant License Number PA 10871 to Richard Hernandez Regalado, P.A. (Respondent). That License was in full force and effect at all times relevant to the charges brought herein and will expire on July 31, 2015, unless renewed.

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JURISDICTION

3. This Accusation is brought before the Board under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 3527 of the Code states in pertinent part:

"(a) The board may order the denial of an application for, or the issuance subject to terms and conditions of, or the suspension or revocation of, or the imposition of probationary conditions upon a physician assistant license after a hearing as required in Section 3528 for unprofessional conduct that includes, but is not limited to, a violation of this chapter, a violation of the Medical Practice Act, or a violation of the regulations adopted by the board or the Medical Board of California."

"...."

5. Section 3502 of the Code states in pertinent part:

"(a) Notwithstanding any other provision of law, a physician assistant may perform those medical services as set forth by the regulations adopted under this chapter when the services are rendered under the supervision of a licensed physician and surgeon who is not subject to a disciplinary condition imposed by the Medical Board of California prohibiting that supervision or prohibiting the employment of a physician assistant.

"(b) Notwithstanding any other provision of law, a physician assistant performing medical services under the supervision of a physician and surgeon may assist a doctor of podiatric medicine who is a partner, shareholder, or employee in the same medical group as the supervising physician and surgeon. A physician assistant who assists a doctor of podiatric medicine pursuant to this subdivision shall do so only according to patient-specific orders from the supervising physician and surgeon.

"The supervising physician and surgeon shall be physically available to the physician assistant for consultation when such assistance is rendered. A physician assistant assisting a doctor of podiatric medicine shall be limited to performing those duties included within the scope of practice of a doctor of podiatric medicine.

"...."

6. Section 3502.1 of the Code states:

"(a) In addition to the services authorized in the regulations adopted by the Medical Board of California, and except as prohibited by Section 3502, while under the supervision of a licensed physician and surgeon or physicians and surgeons authorized by law to supervise a physician assistant, a physician assistant may administer or provide medication to a patient, or transmit orally, or in writing on a patient's record or in a drug order, an order to a person who may lawfully furnish the medication or medical device pursuant to subdivisions (c) and (d).

"(1) A supervising physician and surgeon who delegates authority to issue a drug order to a physician assistant may limit this authority by specifying the manner in which the physician assistant may issue delegated prescriptions.

"(2) Each supervising physician and surgeon who delegates the authority to issue a drug order to a physician assistant shall first prepare and adopt, or adopt, a written, practice specific, formulary and protocols that specify all criteria for the use of a particular drug or device, and any contraindications for the selection. Protocols for Schedule II controlled substances shall address the diagnosis of illness, injury, or condition for which the Schedule II controlled substance is being administered, provided, or issued. The drugs listed in the protocols shall constitute the formulary and shall include only drugs that are appropriate for use in the type of practice engaged in by the supervising physician and surgeon. When issuing a drug order, the physician assistant is acting on behalf of and as an agent for a supervising physician and surgeon.

"(b) 'Drug order' for purposes of this section means an order for medication which is dispensed to or for a patient, issued and signed by a physician assistant acting as an individual practitioner within the meaning of Section 1306.02 of Title 21 of the Code of Federal Regulations. Notwithstanding any other provision of law, (1) a drug order issued pursuant to this section shall be treated in the same manner as a prescription or order of the supervising physician, (2) all references to 'prescription' in this code and the Health and Safety Code shall include drug orders issued by physician assistants pursuant to authority granted by their supervising physicians and surgeons, and (3) the signature of a physician assistant on a drug order shall be deemed to be the signature of a prescriber for purposes of this code and the Health and Safety Code.

"(c) A drug order for any patient cared for by the physician assistant that is issued by the physician assistant shall either be based on the protocols described in subdivision (a) or shall be approved by the supervising physician before it is filled or carried out.

"(1) A physician assistant shall not administer or provide a drug or issue a drug order for a drug other than for a drug listed in the formulary without advance approval from a supervising physician and surgeon for the particular patient. At the direction and under the supervision of a physician and surgeon, a physician assistant may hand to a patient of the supervising physician and surgeon a properly labeled prescription drug prepackaged by a physician and surgeon, manufacturer as defined in the Pharmacy Law, or a pharmacist.

"(2) A physician assistant may not administer, provide, or issue a drug order to a patient for Schedule II through Schedule V controlled substances without advance approval by a supervising physician and surgeon for that particular patient unless the physician assistant has completed an education course that covers controlled substances and that meets standards, including pharmacological content, approved by the board. The education course shall be provided either by an accredited continuing education provider or by an approved physician assistant training program. If the physician assistant will administer, provide, or issue a drug order for Schedule II controlled substances, the course shall contain a minimum of three hours exclusively on Schedule II controlled substances. Completion of the requirements set forth in this paragraph shall be verified and documented in the manner established by the board prior to the physician assistant's use of a registration number issued by the United States Drug Enforcement Administration to the physician assistant to administer, provide, or issue a drug order to a patient for a controlled substance without advance approval by a supervising physician and surgeon for that particular patient.

"(3) Any drug order issued by a physician assistant shall be subject to a reasonable quantitative limitation consistent with customary medical practice in the supervising physician and surgeon's practice.

"(d) A written drug order issued pursuant to subdivision (a), except a written drug order in a patient's medical record in a health facility or medical practice, shall contain the printed name,

address, and telephone number of the supervising physician and surgeon, the printed or stamped name and license number of the physician assistant, and the signature of the physician assistant. Further, a written drug order for a controlled substance, except a written drug order in a patient's medical record in a health facility or a medical practice, shall include the federal controlled substances registration number of the physician assistant and shall otherwise comply with the provisions of Section 11162.1 of the Health and Safety Code. Except as otherwise required for written drug orders for controlled substances under Section 11162.1 of the Health and Safety Code, the requirements of this subdivision may be met through stamping or otherwise imprinting on the supervising physician and surgeon's prescription blank to show the name, license number, and if applicable, the federal controlled substances registration number of the physician assistant, and shall be signed by the physician assistant. When using a drug order, the physician assistant is acting on behalf of and as the agent of a supervising physician and surgeon.

"(e) The medical record of any patient cared for by a physician assistant for whom the physician assistant's Schedule II drug order has been issued or carried out shall be reviewed and countersigned and dated by a supervising physician and surgeon within seven days.

"(f) All physician assistants who are authorized by their supervising physicians to issue drug orders for controlled substances shall register with the United States Drug Enforcement Administration (DEA).

"(g) The board shall consult with the Medical Board of California and report during its sunset review required by Division 1.2 (commencing with Section 473) the impacts of exempting Schedule III and Schedule IV drug orders from the requirement for a physician and surgeon to review and countersign the affected medical record of a patient."

7. Section 1399.545 of the California Code of Regulations states:

"(a) A supervising physician shall be available in person or by electronic communication at all times when the physician assistant is caring for patients.

"(b) A supervising physician shall delegate to a physician assistant only those tasks and procedures consistent with the supervising physician's specialty or usual and customary practice and with the patient's health and condition.

"(c) A supervising physician shall observe or review evidence of the physician assistant's performance of all tasks and procedures to be delegated to the physician assistant until assured of competency.

"(d) The physician assistant and the supervising physician shall establish in writing transport and back-up procedures for the immediate care of patients who are in need of emergency care beyond the physician assistant's scope of practice for such times when a supervising physician is not on the premises.

"(e) A physician assistant and his or her supervising physician shall establish in writing guidelines for the adequate supervision of the physician assistant which shall include one or more of the following mechanisms:

"(1) Examination of the patient by a supervising physician the same day as care is given by the physician assistant;

"(2) Countersignature and dating of all medical records written by the physician assistant within thirty (30) days that the care was given by the physician assistant;

"(3) The supervising physician may adopt protocols to govern the performance of a physician assistant for some or all tasks. The minimum content for a protocol governing diagnosis and management as referred to in this section shall include the presence or absence of symptoms, signs, and other data necessary to establish a diagnosis or assessment, any appropriate tests or studies to order, drugs to recommend to the patient, and education to be given the patient. For protocols governing procedures, the protocol shall state the information to be given the patient, the nature of the consent to be obtained from the patient, the preparation and technique of the procedure, and the follow-up care. Protocols shall be developed by the physician, adopted from, or referenced to, texts or other sources. Protocols shall be signed and dated by the supervising physician and the physician assistant. The supervising physician shall review, countersign, and date a minimum of 5% sample of medical records of patients treated by the physician assistant functioning under these protocols within thirty (30) days. The physician shall select for review those cases which by diagnosis, problem, treatment or procedure represent, in his or her judgment, the most significant risk to the patient;

"(4) Other mechanisms approved in advance by the board.

"(f) The supervising physician has continuing responsibility to follow the progress of the patient and to make sure that the physician assistant does not function autonomously. The supervising physician shall be responsible for all medical services provided by a physician assistant under his or her supervision."

8. Section 1399.546 of the California Code of Regulations states:

"Each time a physician assistant provides care for a patient and enters his or her name, signature, initials, or computer code on a patient's record, chart or written order, the physician assistant shall also enter the name of his or her supervising physician who is responsible for the patient. When a physician assistant transmits an oral order, he or she shall also state the name of the supervising physician responsible for the patient."

9. Section 2234 of the Code, states, in pertinent part:

"The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"...

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

"(d) Incompetence.

"...."

10. Section 2266 of the Code states: "The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

11. Section 2238 of the Code states:

"A violation of any federal statute or federal regulation or any of the statutes or regulations of this state regulating dangerous drugs or controlled substances constitutes unprofessional conduct."

12. Section 2242 of the Code states:

"(a) Prescribing, dispensing, or furnishing dangerous drugs as defined in Section 4022 without an appropriate prior examination and a medical indication, constitutes unprofessional conduct.

"(b) No licensee shall be found to have committed unprofessional conduct within the meaning of this section if, at the time the drugs were prescribed, dispensed, or furnished, any of the following applies:

"(1) The licensee was a designated physician and surgeon or podiatrist serving in the absence of the patient's physician and surgeon or podiatrist, as the case may be, and if the drugs were prescribed, dispensed, or furnished only as necessary to maintain the patient until the return of his or her practitioner, but in any case no longer than 72 hours.

"(2) The licensee transmitted the order for the drugs to a registered nurse or to a licensed vocational nurse in an inpatient facility, and if both of the following conditions exist:

"(A) The practitioner had consulted with the registered nurse or licensed vocational nurse who had reviewed the patient's records.

"(B) The practitioner was designated as the practitioner to serve in the absence of the patient's physician and surgeon or podiatrist, as the case may be.

"(3) The licensee was a designated practitioner serving in the absence of the patient's physician and surgeon or podiatrist, as the case may be, and was in possession of or had utilized

the patient's records and ordered the renewal of a medically indicated prescription for an amount not exceeding the original prescription in strength or amount or for more than one refill.

"(4) The licensee was acting in accordance with Section 120582 of the Health and Safety Code."

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

13. Respondent is subject to disciplinary action under section 2234, subdivision (b), in that he engaged in acts of gross negligence. The circumstances are as follows:

14. From on or about 2001 until 2012, Respondent was employed as a Physician Assistant at a practice in Chowchilla, California, owned by Youssef Hadweh, M.D. ("the Chowchilla practice"). Beginning on or about 2004, Dr. Hadweh ceased to work full-time at the Chowchilla practice. In an interview with a Board investigator, Dr. Hadweh stated he decided at that time to have the practice "run by P.A.s". He further stated that he "just go[es] in there maybe one day a week."

Failure to Execute a Delegation of Services Agreement

15. At no time during Respondent's employment at the Chowchilla practice, did Respondent execute a Delegation of Services Agreement with any physician.

16. The standard of care in California is for physician assistants to be supervised by a physician. The Delegation of Services Agreement is the foundation of the relationship between a supervising physician and the physician assistant, and specifies the names of the supervising physicians and what types of medical services the physician assistant is allowed to perform, how they are performed, how the patient charts will be received and countersigned, and what type of medications the physician assistant will transmit on behalf of the supervising physician.

17. By failing to execute a Delegation of Services Agreement with a physician at the Chowchilla practice, Respondent departed from the standard of care.

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Prescribing Controlled Substances to Oneself

18. Respondent prescribed APAP/Hydrocodone[1] to himself on numerous occasions, including, but not limited to, the following:

a. June 9, 2010, 120 tablets

b. July 26, 2010, 120 tablets

c. September 2, 2010, 120 tablets, with one refill

d. September 29, 2010, 120 tablets

e. October 27, 2010, 120 tablets, with 99 refills

f. November 29, 2010, 120 tablets

g. December 20, 2010, 120 tablets, with two refills

h. January 10, 2011, 120 tablets, with two refills

i. February 18, 2011, 120 tablets with three refills

j. March 18, 2011, 120 tablets with five refills

k. April 14, 2011, 120 tablets with five refills

l. May 16, 2011, 1 120 tablets

m. June 18, 2011, 120 tablets with one refill

n. August 29, 2011, 120 tablets

o. October 24, 2011, 120 tablets with one refill

p. October 10, 2012, 30 tablets

19. The standard of care in California is never to prescribe controlled substances to oneself. Controlled substances should only be prescribed by a treating physician, or licensed midlevel provider under the supervision of a physician, for a legitimate medical purpose.

20. By prescribing controlled substances to himself, Respondent departed from the standard of care.

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[1] Hydrocodone is an opioid narcotic analgesic used to relieve moderate and severe pain. Brand names include Vicodin, Norco, and Lortab.

Failure to Document Medical Care of R.H., M.K., R.L., and L.H.[2]

21. Patients R.H., M.K., R.L., and L.H. each made numerous visits to the Chowchilla practice, and were mainly seen by Respondent. Respondent's medical documentation of these patients between December 2010, and December, 2011, is mostly illegible. The subjective portion of the progress notes during this period do not adequately document the patients' complaints. The documentation of the physical examination of these patients is insufficient for the presenting complaints, the diagnoses, and the treatment plans. Medication records for each visit are not included except for what is being prescribed at each visit. There is no documentation to support the diagnoses, and no consideration of alternate diagnoses. The documentation of the treatment plans is routinely brief and inadequate, and follow-up plans are not documented.

22. The standard of care in California is to maintain complete and accurate medical records for all patients who are seen, and requires that the records be sufficiently legible that they can be read and interpreted by another provider. The standard of care requires that medical records include a thorough history with a review of systems as indicated, a review of the patient's medication list, necessary vital signs, an exam that is appropriate for the given patient complaint, an assessment with consideration of alternate diagnoses, a treatment plan, and a follow-up plan.

23. By consistently failing to adequately document the medical care of R.H., M.K., R.L., and L.H. over a one-year period which included many visits by each patient, Respondent departed from the standard of care.

Prescribing Narcotic Pain Medication Without Documented Need

24. On numerous occasions, Respondent prescribed narcotic pain medication to patients R.L. and M.K. without documented need. These occasions include, but are not limited to, the following:

a. On or about May 7, 2011, Respondent prescribed patient R.L. 45 tablets of APAP/Hydrocodone for a diagnosis of joint pain. Joint pain is not indicated in the reason

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[2] Patients are identified by initials in this Accusation to protect their privacy.

for the visit, is not mentioned in the subjective portion of the note, and there is no documentation of an examination of any of the patient's joints.

b. On or about March 5, 2011, Respondent prescribed patient R.L. 30 tablets of Vicodin. She was being seen for allergies. There is no indication why the Vicodin was required and no mention of any pain in the progress note.

c. On or about December 31, 2010, Respondent prescribed patient M.K. 90 tablets of Norco. She was seen for a cough that day. There is no indication why the Norco was required and no mention of any pain in the progress note.

d. On or about January 29, 2011, Respondent prescribed patient M.K. 90 tablets of Lortab. She was seen for bronchitis that day. There is no indication why the Lortab was required and no mention of any pain in the progress note.

e. On or about April 4, 2011, Respondent prescribed M.K. 90 tablets of Vicodin. She was being seen for low back pain but the documentation includes only an examination of the knees.

f. On or about May 2, 2011, Respondent prescribed M.K. 90 tablets of Vicodin. She was being seen for ear pain and low back pain, but there is no documentation of any examination of the ears or back.

g. On or about December 15, 2011, Respondent documented "Chonic LB pain" in patient M.K.'s medical record and prescribed 60 tablets of Vicodin. There is no documentation of a back examination, neurological examination, or other documentation to support the ongoing need for Vicodin.

h. On or about March 5, 2012, Respondent documented "Chronic low back pain" in patient M.K.'s medical record and prescribed 60 tablets of Vicodin. There is no documentation of a back examination, neurological examination, or other documentation to support the ongoing need for Vicodin.

25. The standard of care in California is to maintain accurate and complete medical records for all patients. When prescribing narcotic pain medication, this includes a thorough history, appropriate physical examination, and documentation of the need for the narcotic pain

medication. The standard of care in California when prescribing controlled substances for pain includes an assessment of the pain, physical and psychological function; a substance abuse history; history of prior treatment; an assessment of underlying or coexisting diseases or conditions; and documentation of the presence of a recognized medical indication for the use of a controlled substance. Furthermore, the treatment plan should state objectives by which the treatment plan can be evaluated, such as pain relief and/or improved physical and psychosocial function, and indicate if any further diagnostic evaluations or other treatments are planned.

26. By prescribing narcotic pain medication to R.L. and M.K. without an appropriate history, physical examination, valid medical indication, assessment of the pain, or assessment of the patient's physical and psychological function, Respondent departed from the standard of care.

Prescribing Zolpidem and Alprazolam Without Documented Need

27. Between May 11, 2011, and April 28, 2012, Respondent repeatedly prescribed zolpidem (Ambien)[3] and alprazolam (Xanax)[4] to patient R.L.. There is insufficient documentation to support these prescriptions. Specifically:

a. On or about May 11, 2011, Respondent noted "a lot of back pain—feels anxious—crying all day." He prescribed 60 tablets of Xanax. There is no mention of anxiety or the Xanax prescription in the assessment/plan section of the note, and no mention of providing counseling or sending the patient for counseling. There is no documentation of the need for this controlled substance, and no evaluation for addictive or drug-seeking behavior.

b. On or about July 15, 2011, Respondent noted "poor sleep—anxious." He prescribed 45 tablets of Xanax and 30 tablets of Ambien. Under assessment/plan, he simply notes "Anxiety—Xanax 0.5 mg TID. Ambien for sleep. Keep cardiology appoint."

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[3] Ambien is a sedative used for the treatment of insomnia.

[4] Xanax is a benzodiazepine used to treat anxiety and panic disorder.

c. On or about August 5, 2011, Respondent noted "very stress again mom ill—Xanax works well." He prescribed 45 tablets of Xanax and 30 tablets of Ambien. Under assessment/plan, he notes "Anxiety—Xanax 0.5 mg TID. 45 Singulair 10mg for allergy. Keep f/u cardiology [illegible]."

d. On or about September 3, 2011, Respondent's subjective note is completely illegible. He prescribed 90 tablets of Xanax. The assessment/plan section makes no mention of anxiety, and in reference to the Xanax prescription, simply states "Xanax 0.5 mg TID."

e. On or about October 21, 2011, Respondent noted "still having a lot of stress." He prescribed 45 tablets of Xanax. The assessment/plan section makes no mention of anxiety or stress, and in reference to the Xanax prescription, simply states "Xanax 1 mg TID #45."

f. On or about October 31, 2011, Respondent's subjective note is silent as to anxiety or trouble sleeping. Nonetheless, he prescribed 30 tablets of Ambien. Regarding this prescription, the assessment/plan section simply states "10 mg Ambien for sleep."

g. On or about January 13, 2012, Respondent noted "poor sleep." He prescribed 30 tablets of Ambien. Regarding this prescription, the assessment/plan section simply states "Insomnia Ambien 10 mg QHS #30."

h. On or about April 14, 2012, Respondent noted "insomnia." He prescribed 30 tablets of Ambien. Regarding this prescription, the"assessment/plan section simply states "Insomnia: Rx Ambien 10mg QHS #30."

i. On or about April 28, 2012, Respondent noted "Worried about more frequent panic attacks." He prescribed 60 tablets of Xanax. The assessment/plan, for the first time, mentions "schedule counseling."

28. The standard of care in California is to maintain accurate and complete medical records for all patients. When prescribing controlled substances, this includes a thorough history, appropriate physical examination, documentation of the need for the controlled substance, and evaluation for addictive behaviors or signs of diversion.

29. By failing to document an adequate history of the complaints supporting his prescriptions for zolpidem and alprazolam, failing to document the medical need for these medications, and failing to evaluate the ongoing need for these medications, Respondent departed from the standard of care.

Prescribing Clonazepam Without Documented Need

30. Between September 11, 2009, and November 2, 2012, Respondent repeatedly prescribed clonazepam (Klonopin)[5] to patient L.H. There is insufficient documentation to support these prescriptions. Specifically:

a. On or about September 11, 2009, one of the medical staff at the Chowchilla practice wrote in the chart "pt called requesting refill for clonazepam, per Richard ok." There is no office visit or progress note that corresponds to this prescription.

b. On or about September 27, 2010, Respondent provided patient L.H. a prescription for 45 tablets of clonazepam 1 mg. The progress note corresponding to this prescription has a single illegible word written in the "subjective" section, and the assessment/plan section refers to "Dental pain," then has a single illegible word followed by "Klonopin 1 mg TID #45."

c. On or about April 15, 2011, Respondent provided patient L.H. a prescription for 60 tablets of clonazepam 1 mg. There is no office visit or progress note that corresponds to this prescription.

d. On or about April 22, 2011, Respondent evaluated patient L.H. for gastroenteritis.[6] At the bottom of the note he wrote "5/13/11 ok Klonopin." There is no history, physical exam, diagnosis, or justification of the need for the clonazepam.

e. On or about September 24, 2011, Respondent saw patient L.H. for a tuberculosis test. In the progress note he wrote "11/2/2011 OK clonazepam 1 mg TID #90 I

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[5] Klonopin is a benzodiazepine used to treat seizure, panic disorder, and anxiety.

[6] Inflammation of the stomach and intestines.

called in to George at DeWitt." There is no history, physical exam, diagnosis, or justification of the need for the clonazepam.

f. On or about September 30, 2011, Respondent provided patient L.H. with a prescription for 90 tablets of clonazepam 1 mg. There is no office visit or progress note that corresponds to this prescription.

g. On or about March 3, 2012, one of the medical staff at the Chowchilla practice wrote in the chart "called in refill to DeWitts clonazepam ok per Richard clonazepam 2 mg BID #60." There is no office visit or progress note that corresponds to this prescription.

h. On or about March 22, 2012, Respondent provided patient L.H. with a prescription for clonazepam 2 mg. The quantity is crossed out twice, so it is not clear how many tablets were prescribed. There is no office visit or progress note that corresponds to this prescription.

i. On or about May 3, 2012, Respondent provided patient L.H. with a prescription for 60 tablets of clonazepam 2 mg. There is no office visit or progress note that corresponds to this prescription.

j. On or about June 8, 2012, one of the medical staff at the Chowchilla practice wrote in the chart "called in refill to DeWitts for clonazepam ok per Richard #60 2 mg." There is no office visit or progress note that corresponds to this prescription.

k. On or about September 28, 2012, Respondent provided patient L.H. with a prescription for 60 tablets of clonazepam 2 mg. There is no office visit or progress note that corresponds to this prescription.

l. On or about November 2, 2012, Respondent provided patient L.H. with a prescription for 60 tablets of clonazepam 2 mg. There is no office visit or progress note that corresponds to this prescription.

31. The standard of care in California is to maintain accurate and complete medical records for all patients. When prescribing controlled substances, this includes a thorough history, appropriate physical examination, documentation of the need for the controlled substance, and evaluation for addictive behaviors or signs of diversion.

32. By prescribing a controlled substance to patient L.H. without an office visit; or without an adequate history, physical examination, or documentation to support the need for the controlled substance prescription; or evaluation of the ongoing need for the medication; Respondent departed from the standard of care.

Inappropriate Use of Antibiotics

33. Respondent diagnosed patient M.K. with an ingrown toenail, as well as viral bronchitis, on or about January 12, 2011. Respondent did not document the presence of a skin infection resulting from the ingrown toenail. Nonetheless, he treated M.K. on this occasion with two antibiotics, Rocephin and Keflex. On or about January 20, 2011, M.K. again presented to Respondent with a cough that was not improving. He again prescribed Rocephin. When M.K. presented yet again on or about January 29, 2011, still complaining of a cough, Respondent again prescribed Rocephin.

34. On or about June 17, 2011, M.K. presented to Respondent complaining of a boil. Respondent prescribed Keflex. Keflex does not adequately cover methicillin-resistant Staphylococcus aureas (MRSA), a common cause of boils and abscesses. M.K. returned the next day, and again four more times over the next ten days, and on each occasion Respondent injected M.K. with another antibiotic, Ancef. Ancef also does not adequately cover MRSA. The wound was never cultured and the antibiotic was never changed to cover MRSA.

35. The standard of care in California is to prescribe antibiotics when a bacterial infection is diagnosed or suspected. The antibiotic that is chosen should treat the suspected or known pathogen. If the patient does not improve, the antibiotic should be changed or the diagnosis reconsidered.

36. By inappropriately treating an ingrown toenail with antibiotics in the absence of a skin infection, by inappropriately and repeatedly treating a case of suspected viral bronchitis with antibiotics, by treating a boil with an antibiotic that does not cover MRSA, and by not changing the antibiotic or reconsidering the diagnosis despite a lack of improvement, Respondent departed from the standard of care.

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Failure to Evaluate a Cough

37. Patient M.K. visited the Chowchilla practice eleven times between December 11, 2010, and February 26, 2011, complaining of a persistent cough. On each of those visits, she was seen by Respondent. M.K. was treated with Keflex[7], Singulair[8], Phenergan[9] with codeine, albuterol[10], azithromycin[11], Qvar[12], Combivent[13], Cipro[14], injectable Rocephin[15], and Macrobid[16]. Her chart does not contain a discussion of possible etiologies of the cough other than bronchitis. No chest x-ray was ordered, nor was any other evaluation of the cough.

38. The standard of care in California is to thoroughly evaluate a cough and consider the possible etiologies of the cough. In simple cases of cough, a clinical diagnosis may be made without imaging studies or laboratory tests. However, in more complex cases, and when a cough persists despite initial therapy, a chest x-ray is indicated. Additional studies such as laboratory tests, allergy testing, or pulmonary function testing may be indicated depending upon the history, physical examination, and clinical suspicion.

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[7] Keflex is an oral antibiotic.

[8] Singulair is an oral leukotriene receptor antagonist, used to treat allergies and asthma.

[9] Phenergan is an antihistamine with a strong sedative effect, used to treat insomnia, allergies, and cough.

[10] Albuterol is a β2-receptor agonist, used to treat asthma.

[11] Azithromycin is an oral antibiotic.

[12] Qvar is a potent glucocorticoid steroid, administered as an inhaler, for the treatment of asthma.

[13] Combivent is a combination preparation of ipratropium bromide and albuterol sulfate, administered as an inhaler. Its FDA-approved usage is in the management of chronic obstructive pulmonary disease. It is also used in the management of asthma, but this use is not FDA-approved.

[14] Cipro, or ciprofloxacin, is an antibiotic that is available as either a tablet or an intravenous injection.

[15] Rocephin is an antibiotic that is available as either a tablet or an injection.

[16] Macrobid is an oral antibiotic that is typically used to treat urinary tract infections.

39. By failing to order any chest x-ray or other laboratory test or evaluation in a case of persistent cough in patient M.K., and by failing to consider any other etiology other than bronchitis, Respondent departed from the standard of care.

Inappropriate Treatment of Allergic Rhinitis

40. On or about April 14, 2011, patient R.H. presented to Respondent with allergic rhinitis (runny nose). Respondent treated R.H. with an 8 mg intramuscular injection of Decadron. Decadron is a potent steroid that typically is used for autoimmune and anti-inflammatory conditions. It has many potential side effects. It is not FDA-approved for the treatment of allergic rhinitis.

41. The standard of care in California is to treat allergic rhinitis with medications such as a non-sedating antihistamine, a nasal steroid, and/or a leukotriene inhibitor.

42. By not treating R.H. with a non-sedating antihistamine, a nasal steroid, and/or a leukotriene inhibitor, but instead by treating him with a potent medication that was not indicated, Respondent departed from the standard of care.

Failure to Appropriately Evaluate Back Pain

43. On or about June 6, 2011, patient R.H. presented to Respondent complaining of back pain. There is no documentation in the subjective portion of R.H.'s chart that would help determine the underlying cause of the pain or rule out serious underlying causes of the pain. There is no documentation of an appropriate examination such as examination of the back, the extremities, or the patient's neurological status. The chart does indicate that a computerized tomography (CT) scan was ordered. No magnetic resonance imaging (MRI) was ordered.

44. The standard of care in California is to thoroughly evaluate all cases of back pain with a thorough history, review of systems, directed physical examination, and laboratory/imaging studies as indicated. The history should attempt to determine the cause of the back pain and evaluate for serious causes of back pain such as malignancy. Typically, imaging is pursued if the pain is chronic, if the pain has not responded to conservative therapy, if a specific cause such as a nerve root impingement is suspected, if a serious underlying cause is suspected, or if the patient has risk factors for serious underlying causes (such as a previous history of malignancy). The

preferred imaging modality is MRI. A CT scan exposes the patient to significant amounts of radiation but provides less clinically useful data than an MRI.

45. By failing to perform an adequate history and physical examination related to R.H.'s complaint of back pain, and by ordering a CT scan rather than an MRI without adequate justification, Respondent departed from the standard of care.

Failure to Appropriately Evaluate Peripheral Edema

46. On or about May 7, 2011, Respondent evaluated patient R.L. for edema (swelling). No history regarding the edema was documented. A cardiac and pulmonary examination were not documented. Respondent treated R.L. with Lasix (a diuretic), but did not attempt to evaluate the underlying cause of the edema. R.L. returned to the Chowchilla practice on or about July 1, 2011, and was seen by Respondent, but he did not address the edema. Respondent saw R.L. again on or about August 5, 2011, and wrote "keep f/u cardiology eval" but did not address the edema. Over this time, the patient lost 13 pounds, which could have been an indication of a serious underlying medical problem.

47. The standard of care in California is to thoroughly evaluate any case of peripheral edema to determine the underlying cause of the edema. This includes a thorough history, physical examination, and an echocardiogram and laboratory studies to evaluate for potential causes of the edema including congestive heart failure, hypothyroidism, kidney disease, liver disease, or low protein levels in the bloodstream.

48. By failing to evaluate R.L.'s peripheral edema to determine a cause, and by failing to follow up on the edema, Respondent departed from the standard of care.

Failure to Monitor Potassium Levels and Kidney Function of a Patient on Lasix and Potassium

49. On or about May 7, 2011, Respondent treated peripheral edema in R.L. by prescribing a high daily dose of Lasix with potassium supplementation. Respondent did not order laboratory tests to monitor her potassium level or kidney function. Treatment with these two medications could have led to a life-threatening potassium abnormality or a serious decrease in her kidney function.

50. The standard of care in California is to monitor a patient's potassium levels and kidney function during therapy with Lasix and/or potassium supplementation.

51. By failing to monitor R.L.'s potassium levels and kidney function after starting her on Lasix and potassium supplementation, Respondent departed from the standard of care.

Failure to Document Evaluation and Treatment of Family Members

52. Respondent stated in his interview with a medical board investigator that he treats family members, sees them after hours, and does not maintain records for these patient visits. Since there are no records being maintained, there is no signature from a supervising physician.

53. The standard of care is to maintain accurate and complete medical records for all patients. The standard of care is for a physician assistant to be supervised for all patient care. The standard of care is not to treat one's own family members.

54. By treating his own family members, by failing to maintain any documentation of his treatment of his family members, and by practicing medicine with respect to these family members without the supervision of a physician, Respondent departed from the standard of care.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

55. Respondent is subject to disciplinary action under section 2234, subdivision (c), in that he engaged in repeated negligent acts. The circumstances are set forth in paragraphs 14 through 54, above, which are incorporated here as if fully set forth. Additional circumstances are set forth as follows:

Failure to Document the Name of a Supervising Physician

56. Respondent never documented the name of his supervising physician in any of the medical records of R.H., M.K., R.L., and L.H.

57. The standard of care in California is for a physician assistant to identify his or her supervising physician in the medical record "each time a physician assistant provides care for a patient and enters his or her name, signature, initials, or computer code on a patient's record", per Section 1399.546 of the California Code of Regulations.

58. By failing to document the name of his supervising physician in medical records he generated, Respondent departed from the standard of care.

Inappropriate Use of Injectable Medications

59. Respondent repeatedly used injectable medications in the care of patients M.K. and R.L. when these injections were not clinically indicated and when an oral medication was more appropriate. Specifically:

a. Respondent gave injections of Rocephin to patient M.K. for a cough when an oral antibiotic (or no antibiotic at all) would have been more appropriate. Paragraph 33 is incorporated here by reference as if fully set forth.

b. Respondent gave injections of Rocephin and Ancef to patient M.K. for recurrent boils. These boils should have been treated with incision and drainage and treatment with an oral antibiotic that covers MRSA. Rocephin and Ancef do not cover MRSA. Paragraphs 36 and 37 are incorporated here by reference as if fully set forth.

c. Respondent gave injections of Vitamin B12 to patient R.L. without documentation of a vitamin B12 deficiency. Even when vitamin B12 supplementation is required, the oral route generally works as well as the injectable route without the risks that accompany injections. Paragraph 70 is incorporated here by reference as if fully set forth.

60. The standard of care in California is to use injectable medications in certain situations: when the oral route is not an option such as when a patient cannot safely swallow, when an appropriate medication is only available as an injectable, or when an injection will produce a quicker or better clinical response than oral medications and such a response is necessary.

61. By inappropriately using injectable medications when an oral medication would have been more appropriate, Respondent departed from the standard of care.

Use of Vitamin B12 Supplementation Without Indication

62. Respondent gave Vitamin B12 shots to patient R.L. on several occasions, including July 1, 2011, and August 5, 2011. On July 1, 2011, fatigue is listed as a diagnosis, but a vitamin

B12 deficiency is never documented. The note on August 5, 2011, does not indicate why the vitamin B12 shot was ordered.

63. The standard of care in California is to prescribe Vitamin B12 supplementation for documented Vitamin B12 deficiency.

64. By prescribing Vitamin B12 supplementation in the absence of documented Vitamin B12 deficiency, Respondent departed from the standard of care.

Poor Documentation of a Boil

65. Respondent evaluated patient M.K. for a boil on or about March 3, 2011, June 3, 2011, and June 17, 2011. Paragraph 37 is incorporated here by reference as if fully set forth. The size or description of the boil was not included on any of the progress notes. There was no mention of whether the boil was draining on any of the progress notes.

66. The standard of care in California is to document the location, size, and description of any skin lesion, such as a boil. This description typically indicates the color of a lesion, whether any elevation from the skin surface is present, and whether any drainage is present.

67. By failing to adequately document the size and description of a boil, Respondent departed from the standard of care.

Failure to Treat a Boil

68. Respondent evaluated patient M.K. for a boil on several occasions. Paragraphs 37 and 76 are incorporated here by reference as if fully set forth. Respondent never attempted to drain the boil and never sent the fluid in the boil to be evaluated by culture and sensitivities.

69. The standard of care in California is to attempt to drain a boil by incision and drainage unless the boil is small enough that antibiotics can adequately penetrate the fluid within the boil and eradicate the bacteria. When a boil is drained, the standard of care is to send the fluid for culture and sensitivities so that the bacteria causing the boil can be determined and appropriate antimicrobial therapy can be instituted or confirmed. If the boil is not drained initially and persists despite antibiotic therapy, drainage of the boil is indicated.

70. By failing to drain a boil and send the fluid for culture and sensitivities, despite the failure of antibiotic therapy, Respondent departed from the standard of care.

Failure to Evaluate Tachycardia

71. Respondent evaluated patient R.H. on or about April 14, 2011, at which time the patient's pulse was elevated at 105, which constitutes tachycardia. There is no history that pertains to the tachycardia, there is no cardiac or pulmonary examination documented, the tachycardia is not addressed in the assessment, and there is no plan outlined to evaluate the tachycardia. There are many potential causes for the patient's tachycardia, but it is possible that this patient who was taking APAP/hydrocodone could have been experiencing withdrawal symptoms. There is no consideration of this possibility documented in the medical record.

72. The standard of care in California is to evaluate any case of tachycardia in order to determine the underlying cause. This evaluation should include a thorough history, physical examination, and evaluation of medications that the patient is taking. Further studies depend on the suspected cause of the tachycardia but may include pulse oximetry, electrocardiograpy, and laboratory tests to evaluate for causes such as hypoxia, cardiac rhythm abrnomalities, electrolyte abnormalities, anemia, and thyroid disorders.

73. By failing to evaluate a case of tachycardia, Respondent departed from the standard of care.

Poor Management of an Abnormal MRI

74. Respondent evaluated patient R.H. on or about September 12, 2011, and noted abnormal MRI results. He documented "refuses f/u" but did not indicate that he had a thorough discussion with the patient regarding the findings of nerve root impingement, and the possible treatments for this condition. Since R.H. was being treated with narcotics for chronic back pain, referral to a neurosurgeon to consider surgery for the nerve root impingement would have been appropriate.

75. The standard of care in California is to evaluate an MRI that is ordered and act upon it as appropriate if there are abnormalities. In some cases, findings such as arthritis, degenerative disc disease, minor disc bulges, or spinal stenosis may not require any additional treatment or evaluation. However, findings such as severe spinal stenosis or nerve root impingement typically require evaluation by a back specialist or neurosurgeon.

76. By not adequately documenting the results of an abnormal MRI, not adequately documenting a discussion of this MRI with the patient, and not referring the patient to a specialist or documenting why the patient refused referral, Respondent departed from the standard of care.

THIRD CAUSE FOR DISCIPLINE

(Incompetence)

77. Respondent is subject to disciplinary action under section 2234, subdivision (d), in that he exhibited incompetence. The circumstances are set forth in paragraphs 14 through 76, above, which are incorporated here as if fully set forth.

FOURTH CAUSE FOR DISCIPLINE

(Prescribing)

78. Respondent is subject to disciplinary action under section 2242 in that he prescribed dangerous drugs without an appropriate prior examination and the existence of a medical indication. The circumstances are set forth in paragraphs 14, 18 through 20, 24 through 36, and 40 through 42, above, which are incorporated here as if fully set forth.

FIFTH CAUSE FOR DISCIPLINE

(Recordkeeping)

79. Respondent is subject to disciplinary action under section 2266, in that he failed to keep adequate and accurate records. The circumstances are set forth in paragraphs 14 through 76, above, which are incorporated here as if fully set forth.

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PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Physician Assistant Board of California issue a decision:

1. Revoking or suspending Physician Assistant's License Number PA 10871, issued to Richard Hernandez Regalado, P.A.;

2. Ordering Richard Hernandez Regalado, P.A., to pay the Physician Assistant Board of California the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Ordering Richard Hernandez Regalado, P.A., if placed on probation, to pay the Physician Assistant Board of California the costs of probation monitoring; and

4. Taking such other and further action as deemed necessary and proper.

DATED: February 12, 2014

GLENN L. MITCHELL, JR.
Executive Officer
Physician Assistant Board
Department of Consumer Affairs
State of California
Complainant

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